Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

PINE CREEK MEDICAL CENTER
9032 HARRY HINES BLVD
DALLAS TX 75235-1720

Respondent Name
Wal Mart Associates Inc

Carrier's Austin Representative Box
Box Number 53

MFDR Tracking Number
M4-12-3564-01

MFDR Date Received
August 13, 2012

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "OUTPATIENT"

Amount in Dispute: $6,599.40

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "…the health care provider did not request preauthorization prior to the services rendered…:"

Response Submitted by: Hoffman Kelley LLP

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
November 9, 2011	Outpatient Hospital Services	$6,599.40	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.403, titled *Hospital Facility Fee Guideline – Outpatient*, sets out the reimbursement guidelines for facility services provided in an outpatient acute care hospital.
3. 28 Texas Administrative Code §134.600 sets out the guidelines for prospective review of health care.
4. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits dated July 27, 2012
   - W1 – WORKERS COMPENSATION STATE FEE SCHEDULE ADJUSTMENT
   - 197 – PAYMENT DENIED/REDUCED FOR ABSENCE OF PRECERTIFICATION/AUTHORIZATION
   - 5056 – PREAUTHORIZATION NOT OBTAINED.

Issues

1. Did the respondent support the insurance carrier's reason for denying procedure codes?
2. Is the requestor entitled to reimbursement?

Findings

1. Per 28 Texas Administrative Code §134.600(c)(1), effective May 2, 2006, 31 *Texas Register* 3566, the carrier is liable for all reasonable and necessary medical costs relating to the health care listed in subsection (p) only in the case of an emergency or "preauthorization of any health care listed in subsection (p) . . . that was approved prior to providing the health care." §134.600(p)(2) states that the non-emergency health care requiring preauthorization includes "outpatient surgical or ambulatory surgical services." No documentation was found to support that this surgical service had been preauthorized. The insurance carrier's denial reason is supported.
2. Review of submitted documents finds no reimbursement can be recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

		June 11, 2013
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.